TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Kevin M Hunter DC

Respondent Name
Arch Insurance Co

MFDR Tracking Number
M4-25-1575-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
March 13, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 21, 2024	Designated Doctor Examination 99456 W5 3 units	$192.00	$192.00

Requestor's Position

"On the original bill, CPT codes 9956 [sic] with modifier W5 at 3 units was billed to indicate the designated doctor exam for maximum medical improvement and impairment rating with a total of 3 regions being examined. According to the first EOB received, 2 units were billed for the different regions of the body for the exam. …An appeal was sent to Gallagher Bassett to indicate that the bill was not paid correctly and Dr. Hunter was still owed $192.00 for the additional region. On 03/13/2025, a reconsideration EOB was received indicating they were upholding their original decision on payment (this EOB however now shows "3" in the Qty area."

Supplemental response submitted May 22, 2025

"We still have not seen any additional payment regarding this dispute."

Amount in Dispute: $192.00

Respondent's Position

The Austin carrier representative for Arch Insurance Co is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on March 18, 2025

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §134.240 sets out the billing requirements and reimbursement guidelines for designated doctor examinations.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- P12/90223 – Workers' compensation jurisdictional fee schedule adjustment.
- 00663 – Reimbursement has been calculated based on the state guidelines.
- 5853 – The amount paid reflects a fee schedule reduction.
- 90202/B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. What rule is applicable to reimbursement?
2. Is the requester entitled to additional reimbursement?

Findings

1. This dispute involves a designated doctor exam for the date of service September 21, 2024. Dr. Kevin Hunter submitted a medical bill that indicates the number of units as 3 for code 99456 - W5. The insurance carrier made a payment that allowed $1,026.00 for 2 units.

   Upon reconsideration, the explanation of benefits indicates the audit of three units, however the insurance carrier maintained the original payment denial. A position statement in support of the denial for the third unit was not submitted with this request for MFDR. The disputed services are reviewed in accordance with the applicable fee guidelines.

   DWC Rule 28 TAC §134.240 (d) states, "When conducting a designated doctor examination, the designated doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and with the modifiers and rates specified in subsections (d)(1) – (7)."

   DWC Rule 28 TAC §134.240 (d)(3) states, "MMI evaluations will be reimbursed at **$449** adjusted per §134.210(b)(4), and the doctor must apply the additional modifier 'W5.'"

   DWC Rule 28 TAC §134.240 (d)(4) states, "For IR examinations, the designated doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. The designated doctor must apply the additional modifier "W5." Indicate the number of body areas rated in the units column of the billing form.

   (A) For musculoskeletal body areas, the designated doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are:

   (I) spine and pelvis;

   (II) upper extremities and hands; and

   (III) lower extremities (including feet).

   (ii) For musculoskeletal body areas:

   (I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

   (II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

   Review of the submitted "Designated Doctor Examination" dated September 21, 2024 states under "Results of Examination" the following three areas were examined.

   - Spine Examination – 0% impairment / $385.00
   - Lower Extremity Examination – 0% impairment / $192.00
   - Upper Extremity Examination – 0% impairment / $192.00

2. The total MAR for the disputed impairment rating is $1,218.00. The insurance carrier paid $1,026.00. The remaining balance is $192.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Arch Insurance Co. shall remit $192.00, plus any applicable accrued interest, to Kevin M. Hunter, DC, within 30 days of receiving this order, in accordance with 28 TAC §134.130.

Authorized Signature

	Medical Fee Dispute Resolution Officer	May 30, 2025
Signature		Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.